TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Brotherhood Mutual Insurance Company

MFDR Tracking Number
M4-15-2992-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… this treatment is necessary to achieve a therapeutic outcome … This medication is medically necessary in order to decrease pain, reduce the need for narcotics and/or other prescription analgesics and to preserve function of the patient."

Amount in Dispute: $3022.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request for Medical Dispute Resolution involves claimed dates of service in dispute of 12/04/2014 as stated on the DWC-060, and yet the only date of service shown on the documentation accompanying the MDR request is for 01/27/2015. The carrier has no record of any services provided by Requestor on 12/4/2014; therefore the carrier is unable to determine the nature of this dispute."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2014	Prescription Medication	$3022.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: No Explanations of Benefits were found for the date of service in dispute.

Issues

Did the requestor submit this dispute in accordance with 28 Texas Administrative Code §133.307?

Findings

Review of the submitted documentation finds that the dispute submitted to the Medical Fee Dispute Resolution section is regarding prescription medication for date of service December 4, 2014. Per 28 Texas Administrative Code §133.307 (c)(2), requests for medical fee dispute resolution must include, in relevant part,

> (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);
> (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;
> (L) when applicable, a copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute;
> (M) a copy of all applicable medical records related to the dates of service in dispute;
> …
> (O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;

Documentation submitted does not relate the date of service in dispute. Therefore, the requestor has failed to support that reimbursement is due for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	July 15, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.